EXHIBIT E

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - ATLANTIC COUNTY

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IN RE:	: CIVIL ACTION
PELVIC MESH/GYNECARE	: CASE NO. 291 CT
LITIGATION	:
	:
	: MASTER CASE NO.
	: L-6341-10
(GENERAL, GROSS, WICKER):	

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NOVEMBER 27, 2012

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Videotaped deposition of STEPHEN M. FACTOR, M.D., held at Jacobi Medical Center, 1400 Pelham Parkway South, Bronx, New York 10464, commencing at 2:08 p.m., on the above date, before Margaret Peoples, a Registered Professional Reporter.

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ALSO PRESENT:

Christopher Campbell, Videographer

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EXHIBITS

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DEPOSITION SUPPORT INDEX

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None

Reserved for Confidential Designation Index as Pursuant to the Protective Order

Defendants did not have any Confidential Designations

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(Whereupon, Exhibit 1 was marked for identification.)

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VIDEOGRAPHER: We are now on the record. My name is Christopher Campbell. I'm a videographer for Golkow Technologies. Today's date is November 27, 2012 and the time is 2:08.

This deposition is being held in Bronx, New York, In Re: Pelvic Mesh, for the Superior Court of New Jersey, Atlantic County.

The deponent is Dr. Stephen Factor.

At this time, will counsel please announce their appearances for the record?

MR. MAZIE: David Mazie, Mazie, Slater, Katz & Freemen on behalf of the plaintiffs.

MR. SNELL: Burt Snell, Butler Snow on behalf of the defendants, Ethicon and Johnson & Johnson.

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VIDEOGRAPHER: The court reporter is Margaret Peoples and will now swear in the witness.

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STEPHEN M. FACTOR, M.D., after having been duly sworn, was examined and testified as follows:

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EXAMINATION

- - -

BY MR. MAZIE:

Q. Dr. Factor, my name is David Mazie and I represent the plaintiffs in two cases in which you are being deposed, hopefully at least one of them today. Certainly, we will find out from the Court whether we will be deposing you on the second case.

How many times have you been deposed before?

A. Many.

Q. How many is many?

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A. I don't keep a precise count, but somewhere close to 125 to 150 over the last 30-plus years.

Q. Over the past 10 years, how many times do you think you have been deposed?

A. It's averaged about six to eight a year.

Q. And what percentage of your cases in which you have been deposed have been on behalf of the defense versus the plaintiff?

A. My breakdown has been about 85 percent for defense and 15 percent or so for plaintiff.

Q. Have you ever worked in a pharmaceutical-type case?

A. Yes.

Q. On how many occasions?

A. I have done products liability now for 20 years, 15 to 20 years. I have testified in virtually none of them, at least with the pharmaceutical cases, but I have been working over that period of time.

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Q. How many times have you been retained in a medical device case over the past 20 years?
A. I've had a long-standing involvement with St. Jude Medical for over 8 to 10 years, leading to testimony last year.
Q. On how many occasions have you been retained where there was an issue of whether or not a medical device was defective?
A. That was, I believe, the only medical device case. The other products liability have been drug or -- and even with the products liability, it was primarily -- I was involved mainly with the experimental studies dealing with the device.
Q. On how many occasions over the past 20 years have you acted as an expert in where there was an issue of whether a drug or medical device was at issue?
A. I don't keep a precise count, so I don't know.

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Q. Can you estimate for us?
A. It's, I'd say, between five and ten cases a year over the past 10 years.
Q. And what percentage of those cases in which there was an issue involving the medical device or drug did you testify or were you an expert, rather, on behalf of the plaintiff versus the defense?
A. They were all for defense.
Q. Fair to say that -- strike that.
Can you tell me how many you said per year?
A. Five to ten.
Q. So, is it fair to say you have acted as an expert in cases in which there was either a medical device or drug at issue on more than 100 cases?
MR. SNELL: Objection, form.
A. I think in total, more likely, yes, because a number of cases dealt with specific issues from individuals dealing with the same subject.

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Q. And in every single case in which there's a medical device or drug at issue, and we're talking at least 100, if not more, you have acted as the expert on behalf of the defense, correct?
MR. SNELL: Objection to the form.
A. Correct, except for one case a number of years ago that I did for plaintiffs in an asbestos litigation.
Q. That doesn't involve a medical device or a drug, correct?
A. No. Correct.
Q. Fair to say in the more than 100 cases in which there's been an issue involving a medical device or drug, you have acted as an expert on behalf of defense in every single one of those cases?
A. Correct.
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. And you've never acted as an expert on behalf of the plaintiff in a case in which there was a medical device or drug at issue, correct?
A. Correct.
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. I'm going to give you some just ground rules, even though you're obviously familiar with them. First of all, you understand you're under oath?
A. Correct.
Q. You understand that your testimony has the same force and effect as if you were sitting before a judge and jury at this time?
A. Yes.
Q. If I ask you a question and you answer it, I'm going to presume you understood the question. If you don't understand the question or any part of it, let me know and I'll rephrase it. But if you answer the question, I'm going to presume you understood it. Okay?
A. Yes.

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Q. Obviously, don't speculate, don't guess. If you know something, you will tell us that. Okay?
A. Yes.
Q. Doctor, are you affiliated with any type of expert organization that advertises your services?
A. None whatsoever.
Q. Do you advertise your services?
A. Absolutely not.
Q. Have you worked with Butler Snow or any of its attorney in the past?
A. I have worked with Mr. Snell once. I don't recall whether he was at Butler Snow at the time, but I have worked with him.
Q. And what type of case did you work with Mr. Snell?
A. It was a Phen-fen case.
Q. And did you actually testify at a deposition in the Phen-fen case?
A. Not that I recall.
Q. And aside from that one occasion with Mr. Snell, have you ever

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worked with him or anyone at his firm?
A. Not to my recollection.
Q. Never worked with Christie Jones?
A. No.
Q. Have you ever worked as an expert or been retained as an expert on behalf of Ethicon, Johnson & Johnson or any of the affiliated entities with Johnson & Johnson?
A. Johnson & Johnson, yes, not Ethicon.
Q. On how many occasions have you acted as an expert for Johnson & Johnson?
A. I don't know the number, but it's -- they were all drug cases and I would be guessing. I don't know.
Q. Have you worked as an expert on behalf of Johnson & Johnson more than ten times?
A. Yes.
Q. Have you worked as an expert on behalf of Johnson & Johnson more than 25 times?

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A. I don't know.
Q. Fair to say that you have worked as an expert on behalf of Johnson & Johnson between 10 and 20 times?
A. By definition.
Q. Is that correct?
A. Yes.
Q. Doctor, you have privileges at Jacobi Medical Center?
A. Yes, I do.
Q. Do you have privileges anywhere else?
A. I don't know if I have active privileges at Montefiore. I don't think I do anymore.
Q. You don't hold any positions at Montefiore?
A. Correct.
Q. What positions do you hold at Jacobi Medical Center?
A. I'm chairman of the department of pathology.
Q. Any other positions?
A. I'm director of anatomic pathology as well as chairman.

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Q. Are those all of your positions at this hospital?
A. At the hospital, yes.
Q. Do you have any positions with any professional organizations?
A. Well, I'm -- I have positions at the medical school. I, also, belong to a number of organizations where I have had positions and still have some degree of active positions.
Q. What medical school are we speaking about?
A. Albert Einstein College of Medicine.
Q. What is your position there?
A. I'm a tenure full professor of pathology of medicine.
Q. Do you have a subspecialty in pathology?
A. Yes, I do.
Q. What is that?
A. Cardiovascular pathology.
Q. You are not a urogynecologic pathologist, correct?
A. That is correct.

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MR. SNELL: Object to form.
BY MR. MAZIE:
Q. What is the difference between a urogynecologic pathologist and a cardiologic pathologist?
A. Well, it has to do not so much with day to day examination of tissues. It has to do with, in my case at least, with my research and the bulk of my writing has dealt with cardiovascular disease of all aspects and, also, my teaching deals with cardiovascular disease. I see urogynecologic specimens all the time as part of my surgical pathology experience, but I'm not a urogynecologic pathologist.
Q. What percentage of the time do you examine urogynecologic specimens?
A. There's no way to calculate that. I sign out surgical specimens on a daily basis. I sign out cytology, generally, on a daily basis. And even the cases that I don't actually -- that I'm not actually responsible for, I see along with my staff during a daily peer

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review conference.
Q. So you can't estimate for me and for this jury what percentage of the time that you actually examine urogynecologic specimens?
A. Absolutely not. There's -- I mean, we receive specimens on a daily basis. The gynecologists tend to operate or oncologic gynecologic surgeons operate one day a week, but our other gynecologists operate daily and we receive specimens virtually every day.
Q. In your professional practice outside of this particular case, how many times have you reviewed or examined any type of transvaginal mesh from a pathologist standpoint?
A. None that I can recall.
Q. And aside from transvaginal mesh, how often do you actually -- strike that.
In your work as a pathologist, how often do you actually examine specimens involving any type of mesh or any type of mesh, surgical mesh?

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A. I was trying to estimate. I would say yearly I see between eight and ten mesh cases from abdominal ventral hernias and inguinal hernias. I, also, see significantly more vascular graphs with -- usually with GORE-TEX as the material used. And, occasionally, I see particularly at autopsy, vascular grafts from large vessels.
Q. If you take GORE-TEX out of the mix, how often do you see any other type of surgical mesh?
A. Well, it's EIGHT to ten hernia cases. And that's -- and other than that, the Dacron used for vascular grafts.
Q. What the hernia mesh made of that you see?
A. Most often, it's, to my knowledge, it's polypropylene, but I don't know that all of them include that.
Q. Doctor, you're board certified?
A. Yes, I am.
Q. And in what discipline?

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A. Anatomic and clinical pathology.
Q. You were board certified in 1995?
A. Correct.
Q. Did you have to take both oral and written boards?
A. It was written and I believe a portion of the anatomic boards were oral at that time, yes.
Q. Did you pass your written and oral boards on the first try?
A. Yes.
Q. Have your privileges in any hospital ever been suspended or revoked?
A. No.
Q. Have you ever been -- strike that.
Has anyone ever filed a complaint against you with the Board of Medical Examiners or any other organizations?
A. No.
MR. SNELL: Form.
BY MR. MAZIE:

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Q. Have you ever been sued for malpractice?
A. I was named in a suit that I had nothing to do with, just as the chairman of the department and then I was subsequently dropped.
Q. Just once?
A. To my knowledge, yes.
Q. Have you ever written any articles involving mesh?
A. No.
Q. Mesh of any sort?
A. No.
Q. Have you ever given any presentations concerning mesh, surgical mesh?
A. No.
Q. Have you ever studied surgical mesh?
MR. SNELL: Objection to form.
A. I don't recall because I have done studies with my surgical colleagues, my cardiac surgical colleagues and whether or not they used

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any mesh materials in those studies, I don't recall whether it did or not.
Q. As you sit here today, you can't recall any presentations you have given on surgical mesh?
A. To my knowledge, I haven't given any presentations.
Q. To your knowledge, you have never done any research on surgical mesh, correct?
A. Correct.
Q. Doctor, what percentage of your income over the past 10 years has been as a result of medical-legal expert work?
A. It's averaged between 25 and 40 percent.
Q. What percentage of your time over the past 10 years has been as a result of medical-legal expert work?
A. It's difficult to total. In general, with all cases, between 10 to 20 hours a week, but not every week. And usually that's during evenings and weekends, other than actually reviewing

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pathology slides that I have to do here in the office, but most of the remaining work is done at night and weekends.
Q. How many cases do you currently have for J&J?
A. None that I recall. They're still active. There may be one or two out there, but I don't know.
Q. Can you estimate for me over the past 10 years how much money J&J has paid you for expert work?
A. I have no idea.
Q. What are you being paid on an hourly basis for this case?
A. $500 an hour.
Q. Do you know how much you have been paid to date?
A. Yes.
Q. How much?
A. 21,000.
Q. Doctor, you have issued one report in this case?
A. Correct.
Q. Linda Gross?
A. Correct.

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Q. That would be dated October 9, 2012?
A. Yes.
Q. And does this report contain all of your opinions in the case?
A. To date, yes.
Q. What do you mean to date?
A. Well, if additional information becomes available, I might be asked to write a supplement, but I haven't done so as of yet.
Q. As of right now, these are all the opinions you have in the case, correct?
A. Right.
Q. And let me ask you, is it fair to say that mesh when it's placed in the human body elicits a foreign body -- I'm sorry. Is it fair to say that when mesh is placed into the human body provokes inflammation?
A. Yes.
Q. And explain to us how that works?
A. The mesh is recognized as a

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foreign material and it elicits an inflammatory response, which is -- includes changes comparable to wound healing with the development of granulation tissue, the laying down of fibrosis, the development of neovasculature. And along with that, it elicits an inflammatory response. And that includes the reaction of mononuclear cells, monocytes that are altered into macrophages and then ultimately, in some cases, multinuclear giant, foreign body type giant cells, along with lymphocytes and rarely eosinophils or mass cells.

Q. And as you sit here today, do you know how much mesh was placed in Linda Gross?

A. How much volumetrically?

Q. Yes.

A. I don't know.

Q. If you took each fiber and stretched it out, do you know how much distance that would be?

A. I have no idea.

Q. In your review of the

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pathology slides for Linda Gross, you saw lymphocytes?

A. Yes.

Q. You saw macrophages?

A. Yes.

Q. Did you see giant cells?

A. I saw some, yes.

Q. Did you see fibroblasts?

A. Yes.

Q. Did you see scar tissue?

A. There was fibrosis, yes.

Q. And how is fibrosis formed?

A. Fibrosis is the response of the body again to healing with the development of granulation tissue which includes fibroblasts and endothelia cells and buds of endothelia cells forming new vessels. The fibroblasts secrete procollagen, which polymerizes and then initially develops a matrix of type three collagen, which is also called reticulin, and then over the course of days and weeks and months, leads to the development of type one collagen, which is the typical collagen present in

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natural tissue, as well as in response to injury.

Q. Doctor, you've reviewed a number of slides with regard to Linda Gross, correct?

A. Yes.

Q. Can you tell me how many slides?

A. I have to total them up. There were 19 slides, but then subsequently I saw a second set, one initially with the plaintiff's slides and then I saw a set of defense slides. And there were, also, some blanks in there. So, my -- as best as I can tell from my report, and I didn't quantify them, but just going by the number of cases, the number of accession cases and the number of slides listed with those cases, I believe there are 19.

Q. 19 pieces of tissue were examined by you?

A. There may be even more tissue on one slide, but 19 slides.

Q. Can you estimate for me how

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many pieces of tissue you actually examined?

A. I can't tell you that.

Q. Approximately.

A. I have no idea. It's, approximately, 19. But whether any one slide had two separate pieces of tissue, I can't tell.

Q. From how many operations -- strike that.

The, approximately, 19 slides that you examined, how many different sources did they come from? And what I'm asking about sources, sources within Linda Gross' body.

A. Well, this is separate accessioned tissues that are from the gynecologic track, as well as elsewhere, but total is the total number of accession cases.

Q. And from how many operations did those slides come from?

A. By my count, eight.

Q. Do you know how many operations Linda Gross has had?

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A. I believe 18.
Q. As you sit here today, can you tell us those areas of Linda Gross' body, those tissue samples came from that you examined in this case?
A. I can go by what or how they are labeled or how they were identified. One was rectovaginal mass. One was left posterior vagina, right posterior vagina. Another was large bowel biopsy, upper posterior vagina and ischial spine. It wasn't identified as the left or right. And then a separate one from left ischial spine, a separate one from soft tissue left buttock. Another one from left buttock. Another from fallopian tubes and another from retropubic mass.
Q. Doctor, is it fair to say in those areas where you did not examine any tissue samples you have no opinion as to whether and to what extent there was any type of inflammation or fibrosis?
A. Correct.
Q. Doctor, is it fair to say that wherever the mesh is --

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A. Can I add something?
Q. Sure.
A. Because in the defense slides, there were other tissues that were not included with the plaintiff's slides.
Q. I'm talking about any slides you've reviewed.
A. Okay.
Q. Just so we're clear, you have no opinions on what is going on any part of Linda Gross' body aside from what you saw on those particular tissue -- s?
A. No.
Q. -- samples?
MR. SNELL: Object to form.
A. But the ones I've identified for you were from the plaintiff's slide I initially reviewed and then I subsequently reviewed similar tissues from the plaintiff, but I, also reviewed others that were not included with the plaintiff's slides.
Q. In addition to the 19 or?
A. In addition to the number of

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cases, the accession cases I, also, reviewed other slides.
Q. So your answer has to do with two questions ago. Let's make sure. Is that correct?
A. I believe I said there were eight accession cases and I listed those eight. There are additional other slides from the defense set of slides that I, also, reviewed that were not included with the plaintiff's slides.
Q. Do you have a list of what those --
A. Yes. That includes the cervix and uterus, it includes the gallbladder, it includes hemorrhoids, and that's it.
Q. Okay. And just so the record is clear, aside from what the slides you looked at, whether they be from the plaintiff or the defense, you have no opinion as to those other areas of Linda Gross' body and what was transpiring within those other parts of her body?

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A. Correct.
Q. So whether or not there's inflammation, fibrosis or anything else going on in her body, if you didn't examine a tissue slide relating to it, you have no opinion on it?
A. Correct.
Q. And the -- just so I'm clear, is it fair to say that any time there is mesh, the tissue next to the mesh has inflammation or becomes inflamed?
MR. SNELL: Objection to form.
A. Not universally, no. There are areas even in these slides that show mesh without inflammation or without any meaningful inflammation.
Q. Are you going to be rendering an opinion in this case -- strike that.
Is it fair to say that the majority of the time where mesh is touching tissue it will cause inflammation in that tissue?

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MR. SNELL: Objection to form.
A. It's variable. The inflammation that's present in some areas is obvious and in other areas, there's virtually no inflammation. Or if there's inflammation, it may be associated -- or it is associated with other findings, including the presence of hemosiderin.
Q. What is the significant of the presence of hemosiderin?
A. It's a natural response or natural result from surgery during the course of surgery regardless of what the surgical procedure is, there is disruption of blood vessels bleeding into the tissue and then the blood breaks down, the hemoglobin is released from the red cells and turns in to hemosiderin which elicits an inflammatory response.
Q. How long does it take for hemosiderin to form?
A. Within four to seven days, you see hemosiderin in the tissue.
Q. So if hemosiderin is shown

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on some of these pathology slides, as it relates to the actual operation from which the tissue was taken or a prior operation?
A. There's no way to determine that other than the immediacy of the hemosiderin to the tissue that's being resected at the time. Whether it was there prior to that, it's unlikely, but theoretically it's possible. Hemosiderin persists in the tissue, essentially, forever.
Q. Well, I'm trying to understand. So if there's an operation and they take a piece of tissue to send to pathology, does hemosiderin continue to form from that point forward?
A. Hemosiderin -- you mean once the tissue is out of the body?
Q. Yes.
A. No.
Q. So, once the tissue is taken out of the body, it's then sent to pathology, correct?
A. Sent in fixative. It

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doesn't change at all from that moment on.
Q. You said it takes four to seven days for hemosiderin to form.
A. Once you get bleeding in the tissue, from the surgical procedure, you will develop breakdown of the red cells and the development of hemosiderin. So, obviously, the hemosiderin is not for the surgical procedure that was done at the time of the resection, it was done -- or is associated with procedures that were antecedent to the procedure.
Q. That was my point. I want to make sure we were on the same page.
So, if a tissue sample shows hemosiderin, that relates to a prior procedure?
A. Correct.
Q. And so you are not giving any opinion in this case as to how often mesh causes inflammation in the tissue?
MR. SNELL: Objection to form.
A. All I said was that the

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inflammation associated with the mesh is variable. There are areas with virtually no inflammation and that are areas with more obvious inflammation.
Q. My question is, you are not giving an opinion in this case on a global scale as to how often the Prolift mesh will cause inflammation in the adjoining tissues?
A. I don't understand the question.
MR. SNELL: Object to form.
BY MR. MAZIE:
Q. Okay. Well, you're giving opinions in this case in the tissue samples you examined, correct?
A. Correct.
Q. Beyond those tissue samples, there's an overall question I'm asking you. And that is, whether you're giving an opinion as to how often and to what extent the Prolift mesh will cause inflammation in the patient's tissues.
A. You are talking about --
MR. SNELL: Objection to

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form.
Q. Global?
A. -- global patient's tissues. The answer is, no.
Q. You are not giving that opinion?
A. No.
Q. Doctor, were there is inflammation, will that inflammation inflame nerves?
A. Say that again.
Q. Where you do have a situation where the mesh causes inflammation, will the inflammation to the extent there's nerves there, inflame the nerves?
MR. SNELL: Objection to form.
A. Only if one identifies evidence of neural involvement by inflammation, which I did not.
Q. I'm asking you theoretically.
A. Theoretically, if you have nerves and tissue and you have

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inflammation, you can theoretically develop a neuritis, an inflammatory process involving nerves for any surgical procedure, regardless of what the procedure is and regardless of whether you use foreign material.
Q. But my question is, if you have a situation where the Prolift mesh is causing inflammation and there's nerves within that tissue, is it fair to say that can inflame the nerves?
MR. SNELL: Objection to form.
A. Theoretically, if one sees it. But, if it's not seen, I can't answer in the global because we're not talking about the global picture. I'm talking about Mrs. Gross. And in that case, there is no inflammation of nerves, so I comment further than that.
Q. You don't know what -- you didn't examine every nerve in every part of Mrs. Gross' pelvic area, correct?
A. I examined the nerves that were present in all of the tissues that I

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have identified that were present after being removed from her. In none of those nerves was there evidence of significant inflammation of nerves.
Q. You don't know what went on or what is going on in the rest of her nerves or the rest of her tissues because you didn't examine them, correct?
MR. SNELL: Objection to form.
A. Well, that's a theoretical and, essentially, absurd comment. There's no way to know that without a biopsy, without knowing in other sites what is happening to nerves. There's no -- absolutely no scientific or otherwise way to know that.
Q. And I asked you hypothetically if you have a situation where there's inflammation, can that cause inflamed nerves. And you called it neuritis.
MR. SNELL: Objection to form.
A. I said, theoretically, one

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could have inflammation causing a neuritis, but one has to demonstrate it to make the diagnosis of neuritis.
Q. Doctor, how would you characterize the inflammation that you saw within the tissue slides?
A. As I indicated earlier, it was variable. There were areas with virtually no inflammation or very mild inflammation. There were areas with inflammation, particularly in the pictures that I saw today, areas predominantly associated with the presence of hemosiderin in the tissue. And there were a few areas where the inflammation was more significant.
If taking the entire samples of tissue with it and without mesh -- and, also, by the way, there's fat necrosis which causes inflammation, taking all that together, I would say the overall picture is one of mild to minimal in some cases inflammation.
Q. And in some instances, is the inflammation that you saw more

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severe?
A. In a few areas, the inflammatory response is more active. I don't know that I could quantify it as severe. If one is to do this from a scientific perspective, one would actually want to know the entire picture of inflammation. This is not a picture -- the tissues do not show a picture of severe inflammation throughout. There are few areas where the inflammatory response is more active and a few other areas where the inflammatory response is more active, but explained by other things, such as, as I said, hemosiderin or fat necrosis.
Q. Doctor, does the -- when there's inflammation, does inflammation remain or does it then change into fibrosis?
A. Inflammation and fibrosis are two separate processes. They go together to a certain extent, but the fibrosis is a response, as I indicated before, to wound healing, granulation

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tissue, laying down of collagen. Inflammation is, initially, associated with the macrophage and giant cell inflammation associated with foreign material, foreign bodies and that includes hemosiderin and fat necrosis, generally persists for long periods of time, sometimes as long as one can track the process, but it is not -- inflammation and fibrosis go together but not directly.
Q. Is it fair -- strike that.
Are you saying that inflammation does not cause fibrosis?
A. Well, depends what the inflammation is. If you have an abscess in the tissue due to infection, obviously you're going to get fibrosis as a result. But inflammation, per se, if it damages structures, if it damages the heart muscle, you will get fibrosis as a response to that. But when you're dealing with tissues, as we are in this case, the inflammation, per se, is not the cause of the fibrosis.

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Q. Doctor, do you have an opinion as to what the cause of the fibrosis is that you saw within Ms. Gross' body?
A. It's the normal response to -- that falls under the broad category of wound healing with -- as I said before, granulation tissue, laying down of collagen. And together with that, there's a macrophage response that in some areas is associated with the mesh or in some areas is associated with other phenomenon going on in the tissues.
Q. Doctor, are you rendering an opinion in this case as to how mesh works within the female body?
A. No.
Q. Do you have an understanding of how the mesh is intended to work within the female body?
A. Only in very broad senses. I mean, I'm not a bioengineer or mechanical engineer. I understand the general concept of support of the tissues, but I'm not here as an expert in

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that area.
Q. Doctor, do you have an understanding that the mesh is intended to have scar tissue form within it?
A. Yes.
Q. And did you see fibrosis or scar tissue form within the pieces of mesh that you saw on the slides?
MR. SNELL: Objection to form. Can you read that question back, actually?
- - -
(Whereupon, the requested portion was read.)
- - -
MR. SNELL: My objection holds.
THE WITNESS: There is fibrosis in the tissue associated with the mesh.
BY MR. MAZIE:
Q. I'm not sure if I understand your answer. There's fibrosis in the tissue associated with the mesh. What does that mean?

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A. Well, it's -- one of the problems in dealing with tissues from the vaginal wall is that the vagina is fibrous tissue surfaced by mucosa. And so, attempting to quantify the degree of fibrosis in the tissue is very difficult. One can see fibrous tissue surrounding mesh fibers. One can see fibrous tissue in areas of other damage, including fat necrosis and hemosiderin deposition, but to attempt to quantify it when you have a background of fibrosis is very difficult. There's no one way to pick out the fibrous tissue that formed as discrete scar related to the mesh from the tissue that's normally present in the vaginal stroma. There is fibrous tissue around mesh fibers and, presumably, that's fibrous tissue that formed as a response to the mesh.

Q. Fair to say -- first of all, let me back up. Are you rendering any opinions in this case as to what the cause was of the fibrous tissue or the fibrosis that you visualized on any of

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these slides?

A. It's a response to the surgery. It's a response to the presence of mesh. It's a response to the other phenomenon that were present in the tissue, including bleeding and fat necrosis.

Q. Are you rendering an opinion in this case as to whether and to what extent any of the fibrosis that you saw on the slides was the result of mesh versus something else?

A. As I just indicated, there is evidence of fibrous tissue associated with the mesh fibers. To quantify that or to separate that from the surrounding fibrous tissue, in my opinion, is very difficult, if not impossible.

Q. So you are not going to tell this jury at trial when showing a piece of -- or a slide that shows fibrosis whether that fibrosis comes from the mesh or whether it's comes from something else?

MR. SNELL: Objection to

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form.

A. You are asking, am I going to or not going to?

Q. Are you going to -- do you have -- let me ask it this way. Do you have any opinions in this case as to what the specific cause was of any of the fibrosis that you saw in any of the slides?

A. Yes.

MR. SNELL: Objection to form.

THE WITNESS: I said before, it formed in response to the mesh, it formed in response to other injuries in the tissue.

BY MR. MAZIE:

Q. I understand that those are the things that can cause the fibrosis. My question to you is, are you going to be able to look at fibrosis and say this actual fibrosis here is as a result of mesh, or this fibrosis is not the result of mesh, it's a result of something else?

MR. SNELL: Objection TO

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form. Are you taking about like every strand of fibrosis, every strand of fiber?

MR. MAZIE: Yes, any of them. Any of them.

MR. SNELL: Object to form, I mean --

THE WITNESS: All that I can do and I think any examiner can do is to assess the presence of fibrous tissue in its immediate environment. Mesh fibers are present. There is fibrous tissue around -- between mesh fibers and presumably that the mesh fiber elicited the collagen deposition of fibrosis. There are other areas, as I said before, with fat necrosis and with hemosiderin that, also, are within an area of fibrosis and presumably that fibrosis was associated with those changes. But to try and quantify the extent of the fibrosis that's present related to any one of

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those processes, I believe, is not possible.
BY MR. MAZIE:
Q. Doctor, are you going to be rendering any opinions in this case on mesh contraction?
A. No.
Q. Doctor, are you going to be rendering any opinions on the size of the mesh pores?
A. No.
Q. Doctor, are you going to be rendering any opinions in this case on whether a scar net formed or scar bridge?
A. Well, I didn't see anything that was -- that could be, at least in my understanding of scar bridges, that could be interpreted as a scar bridge. There was -- as I said, there was fibrous tissue in the tissues, there were mesh fibers and there were the other changes that I indicated. There was nothing that I could identify as a bridge.
Q. Are you rendering an opinion in this case that there was no scar

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bridge or scar net formed anywhere within Linda Gross' body?
A. Well, I didn't see everywhere within Linda Gross' body. All I saw was the tissues that I indicated before. In those tissues, I see nothing that indicates the presence of a bridge. And if I'm asked that question, that's my answer.
Q. Doctor, do you have an opinions in this case on how the mesh itself will change within the body?
MR. SNELL: Objection to form.
A. I don't understand your question.
Q. Do you have an understanding of what happens to mesh once it's surgically placed within the female body?
MR. SNELL: Same objection, form.
A. I don't understand that question, either.
Q. Do you have an understanding -- I don't know how else to

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say it more simply.
Do you have an understanding of how the mesh changes, if at all, once it's surgically placed into the body?
A. Are you asking about degradation of the mesh?
Q. I'm asking you about about degradation. I'm asking you whether it contracts. I'm asking you whether it becomes brittle or hard. I'm asking any of those things?
MR. SNELL: Let me object to the form. Are you talking Prolift mesh?
BY MR. MAZIE:
Q. Prolift mesh, of course.
A. I see no evidence of degeneration. I see no evidence, in my experience of polypropylene, ever undergoing degeneration of tissues. It persists for years in a state comparable to the way when it is placed in the body. I see that in vascular specimens for years. And I see nothing in these tissues, other than the disruptions

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associated with the sectioning, the histological processing of the tissue that indicates there's any change in the mesh fiber.
Q. Aside from that one opinion that you do not see any degeneration of the Prolift mesh, do you have any other opinions on what happens to the mesh once it's placed in the female body? I'm talking only about Prolift mesh.
A. No.
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. If there's inflammation, does it go through a process -- let me ask it a different way. It's kind of a lead up.
You talked about active inflammation earlier, correct? You saw no evidence of active inflammation or did I misunderstand you?
A. No. I think that's a misunderstanding because I have no way of know whether those inflammatory cells

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are, in fact, active or quiescent.
MR. MAZIE: By the way, Burt, to the extent that since this is a deposition that either will be completed today as to Mrs. Wicker or on another occasion, any of the questions I'm asking him about his background, about the overall response of the mesh, things that are generic to both cases, I'm assuming you will agree that I can use those questions in both cases, so I don't have to ask him the same questions again at the second deposition, if there is a second deposition?
MR. SNELL: I don't know if I can agree to that because they are different cases with different pathologic aspects from my limited attorney's understanding. So, what his background was and legal work and payments and things like that, general questions about in general how the inflammatory

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process happens or how collagen lays down, those are general things, but --
MR. MAZIE: I'm not --
MR. SNELL: I'm confused by your question.
MR. MAZIE: The question really relates to his background, it relates to whether he has any opinions on the pore size or whether there's degradation or how it effects the female body generically, Prolift mesh, all those questions would be the same for both cases. They're not specific to one versus the other. So all I'm saying is, I'm going to ask him now, so I don't have to ask him the exact same questions and get the exact same questions either later today or another day. It would be silly.
MR. SNELL: If they're general questions, they're general questions. I just don't

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understand -- if you put in the context of Wicker, then there may be differences, there may be things he saw that have bearing upon inflammation, there might be other causes of inflammation. That's why I'm note sure if I can agree to that. I'm not trying to be difficult. I'm not a pathologist, so there may be differences. I don't know.
MR. MAZIE: I'm going to take the position that anything that I'm asking him today that is generic as to the mesh or, obviously, relating to his background or anything like that or as to science regarding macrophages and inflammation and how fibrosis formed can be used on any case that he's been identified as an expert on in the consolidated cases.
All right. Why don't we go off the record.

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VIDEOGRAPHER: The time is now 2:57. We are going off the record.
- - -
(Whereupon, a brief recess was taken.)
- - -
VIDEOGRAPHER: The time is now 3:05. We are back on the record.
BY MR. MAZIE:
Q. Let's go to your report now, Doctor. In the first paragraph, you state fibrosis --
A. What page?
Q. Conclusions. You say that fibrosis, whether it's secondary to traumatic or -- how do pronounce that?
A. Iatrogenic.
Q. Iatrogenic injury or response to tissue necrosis or damage elicits a chronic inflammatory response in association with the maturation of the collagen fibers.
Is what you are saying there

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fibrosis itself elicits a chronic inflammatory response?
A. There are inflammatory cells that are associated with the development of granulation tissue that will persist in the tissue once the collagen and the new vessels have formed.
Q. So, sometimes inflammation causes fibrosis, correct?
A. Well, it's not causing the fibrosis. There's an injury to the tissue of one sort or another that leads to fibrosis. The inflammatory response is part of that.
Q. Okay. And if there is inflammation as a result of the fibrosis, will you be able to see that in the slides?
A. Well, you can see -- certainly see the inflammatory cells and the presence of the collagen. They are a normal component of healing regardless of what, as I said here, regardless of what the injury is.
Q. You say lower down, foreign

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bodies are present, the inflammatory response is chronic and persistent. What does that mean?
A. That the macrophage and giant cell response -- the macrophage and giant cell response will persist in the tissue in some cases forever. It will -- even in situations where you look at surgical suture granulomas ten years later, it will still be inflammatory cells, macrophages in a few lymphocytes.
Q. Is it fair to say as a general proposition where mesh -- and I'm talking about Prolift mesh -- is placed within the female body where there's an inflammatory response is going to be chronic in many instances?
A. Almost exclusively, yes.
Q. So, any time there's a Prolift mesh, there will be a chronic inflammatory response within the female body?
A. Of one degree or another. It's not universal. In other words, you don't see inflammation all over the

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place. You see it in selected areas.
Q. But that inflammation itself will be chronic?
MR. SNELL: Objection to form.
A. Chronic inflammation has two definitions. One is in -- relative to the type of inflammatory cell that's present, just like acute inflammation tends to mean neutrophils and occasional eosinophils. Chronic inflammation is composed of lymphocytes, monocytes, macrophages and occasionally mass cells. That's a particular terminology that's used in a pathologic sense. It's not a temporal sense. It has some temporal component because the more chronic inflammatory response tends to follow the more acute inflammatory response. So there is a time dependency. But when you are talking about chronicity, long-standing process, that's a different kind of chronic.
Q. Okay. Let's talk about the temporal relationship to the chronic

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inflammatory response from the mesh. Okay?
Where there is a chronic inflammatory response from the mesh in the female body that mesh will stay inflamed for how long?
MR. SNELL: Objection to form.
A. Well, the concept of inflamed, generally, indicates an act of process of inflammation. And that's not what is present, at least as best as we can tell. There is inflammatory cells as a result of the foreign material, but they aren't necessarily doing anything in an inflammatory process. In other words, they're not, to the best of my knowledge, releasing enzymes or other substances in the tissue that have an adverse effect on the tissue, they're just there.
Q. Where there is that type of chronic inflammatory response, how long will it last?
A. Potentially, forever.
Q. So, when there is a chronic

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inflammatory response from the mesh itself, it's permanent in nature?
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. That response.
A. If there's inflammation, it can persist, essentially, forever.
Q. You would expect that, where there is inflammation, that the inflammation will persist within the body until the person dies?
A. Correct.
Q. And you say that for some unknown -- I'm sorry. You say for unknown reasons, some patients may have a much more intense response than others even when using similar materials and surgical techniques. What did you mean by that?
A. That there's patient variability, unpredictable patient variability regardless of what the materials are, that some patients react more actively, more exuberantly to

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foreign material than others. And you can see this in a number of different situations. It's -- there's no way to understand it, to predict it, to even truly understand the mechanism, whether it's an allergic phenomenon or some other phenomena, it's not known.
Q. So it's fair to say that the mesh will react differently within different women?
MR. SNELL: Objection to form.
A. Well, I don't know that. I'm just -- this was a general statement of observations with foreign materials in many different situations where, in some cases, they're of a much more pronounced inflammatory response with similar materials versus other patients. I can't speak to the vast population of patients with mesh other than the mesh that I have seen in hernia procedures.
Q. You're experience as a pathologist in examining mesh is that some patients have a much more intense

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inflammatory response to the mesh as opposed to others?
A. Well, I don't -- as I said, I don't know that's true with mesh. I haven't -- most of the cases of mesh that I have seen in regard to hernias were removed for other reasons, either adhesion to other sites to other organs and in many cases due to infection. So it's difficult to generalize to meshes as a class of materials.
Q. All right. Then, we'll back it up one. And it's fair to say that it's your opinion that when foreign bodies, such as mesh, are placed into the body, some people have more of an intense response, inflammatory response to the foreign body as opposed to others?
MR. SNELL: Objection to form.
A. As I said, I don't know I can generalize to mesh because I don't have the experience, other than that which I have indicated. The statement had to do with foreign material across

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the spectrum of foreign materials used in surgical procedures.
Q. So you can't give us an opinion one way or the other as to whether or not mesh, in particular Prolift mesh, affects different people differently?
A. Correct.
Q. And you can't give an opinion with regard to Prolift mesh as to what type of inflammatory response is expected within the average person?
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. Or the average female.
MR. SNELL: Same objection.
A. Well, my understanding is that the type of inflammation is what I have described. That it's mononuclear and macrophage inflammation with fibroblast as a general response to the presence of the mesh material.
Q. But can you quantify what is the expected inflammation; in other

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words, how bad or how severe that inflammation is in the typical female anatomy?
MR. SNELL: Objection to form.
THE WITNESS: I would have to look at large numbers of specimens to be able to answer that and I can't answer that.
BY MR. MAZIE:
Q. So you don't have such an opinion?
A. Correct.
Q. Do you have any opinions as to whether someone who has a pre-existing chronic pain syndrome is affected differently by the mesh?
A. I do not, no.
Q. You say that surgery, per se, regardless of whether foreign material is used, including sutures, will lead to tissue damage with necrosis of connective tissue and fat; is that correct?
A. Correct.

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Q. Then you say, there's always some degree of associated damage to blood vessels and tissue nerve bundles leading to entrapment. These responses are not unique to mesh. What do you mean by that?
A. I think precisely what I said, that the surgical procedure, itself, if the tissue has nerve bundles and, obviously, has -- unless we're dealing with tendon or similar tissue, has blood vessels and often adipose tissue, there's going to be damage to those tissues that will be affected by the healing process.
Q. We touched on this earlier. Doctor, do you agree that the mesh itself can cause scar tissue?
MR. SNELL: Objection to form.
A. The mesh cause fibrosis. It depends on how one defines scar tissue.
Q. How do you define scar tissue?
A. It's not an easily defined

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process. Obviously, if one makes an incision in the skin, a scar will form. That's easily identifiable because there's an absence -- there are changes in the epidermis and there's an absence of skin appendages in the underlying tissue and we see that grossly, as well as microscopically. In dealing with tissues, such as mesh implanted in vaginal tissue, there is fibrosis, there's no question, but -- and one could, based on the general concept that when you have surgical disruption of the tissue, you will develop fibrosis which is equivalent to scar. I would agree that there is some -- there's scar tissue, but it's not as easily definable as it is in certain tissues because of the nature of the underlying tissue itself.
MR. MAZIE: I object and move to strike as nonresponsive.
BY MR. MAZIE:
Q. Doctor, all I've asked you was, does the mesh cause scar tissue.

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A. I think I've answered it.
Q. Well, I don't understand your answer, Doctor.
A. Well, that's different.
MR. SNELL: That's not a basis for an objection.
BY MR. MAZIE:
Q. I don't think your answer was responsive.
MR. SNELL: I think it was.
Q. Let me ask you simply, does the mesh cause fibrosis?
MR. SNELL: Objection tp form.
A. Yes.
Q. Is fibrosis different than scar tissue?
A. Under certain circumstances, yes.
Q. Okay. Within Linda Gross, is the fibrosis different than scar tissue?
MR. SNELL: Object to form.
A. It is not easily discernable whether she has a well-defined scar or

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scars versus just deposition of collagen in the tissue surrounding the mesh.
Q. And if the mesh itself is the cause of the -- strike that.
Mesh doesn't cause scar tissue unless there's an incision related to that, is that correct?
A. No. One has to implant, imbed the mesh or implant the mesh in the site, one will develop, obviously, disruption of the surrounding tissues.
Q. You say on the -- on page 5 that Mrs. Gross, also, had evidence of chronic endometriosis in the uterus in the specimen, possibly indicating that she had or was susceptible to chronic inflammation in her pelvic organ. Do you see that?
A. Yes.
Q. Doctor, can you give an opinion within a reasonable degree of medical probability that Linda Gross was susceptible to chronic inflammation in her pelvic organs?
A. All I can say within a

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degree of medical probability is that she had inflammation in her pelvic organs. The -- at least involving the uterus. More than that, I can't say.
Q. And what you are saying is she had endometriosis?
A. No. Endometritis and endometriosis is two different things.
Q. You're saying she had evidence of endometritis in her uterus?
A. In the lining of the -- endometrial lining of the uterus, she had inflammation.
Q. You can't give an opinion within a reasonable degree of medical probability as whether or not she was susceptible to chronic inflammation in her pelvic organs outside of the uterine lining?
MR. SNELL: Objection to form.
A. Of the other pelvic organs that I examined, which included the cervix and the fallopian tubes, she did not have inflammation of those sites.

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Q. So I want to make sure I understand this. You are not giving an opinion that Linda Gross was susceptible to chronic inflammation in her pelvic organs?
MR. SNELL: Objection to form.
A. Other than the inflammation she had in her uterus.
Q. Doctor, you saw in the slides that there were entrapment of multiple nerves?
A. Correct.
Q. You can't tell us within a reasonable degree of medical probability as to how those nerves became entrapped?
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. Correct?
A. They are a response to the surgical reparative process.
Q. How do you know that?
A. Because they're occurring in the site of surgery.

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Q. You mean an actual area where there was incision?
A. Yes. There was implanting of -- there was an incision, there was placement of mesh, there was removal of mesh. There are multiple procedures taking place in those tissues that will lead to fibrosis and surrounding of nerve tissue, nerve fibers.
Q. We, also, know that the mesh can cause fibrosis as well; correct?
A. Yes, but it's a natural response to any surgical procedure, whether regardless of whether you use mesh or not, that you will see nerve fibers enveloped or surrounded by fibrous tissue.
Q. You can't tell us within a reasonable degree of medical probability as to whether those nerves that were entrapped were the result of the actual surgical process or whether they were the result of fibrosis due to the mesh itself?
MR. SNELL: Objection to

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form.
A. There's absolutely no way anyone scientifically can separate those two processes.
Q. Now, you talked about the fact that you saw a neuroma. What is a neuroma?
A. A neuroma, in this case, is what's called a traumatic neuroma. It is secondary to disruption or transection of nerve, and it subsequently leads to the proliferation of little nerve fibers that extend out from the end of the disrupted segment.
Q. Could that neuroma have been caused by a reaction to the mesh?
A. No. It's a reaction to transection. It's a surgical process.
Q. How do we know that?
A. Because that's how traumatic neuromas develop. They're either disrupted by trauma, external trauma or they're disrupted by iatrogenic trauma. They are not responding to the presence of surrounding mesh.

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Q. How many neuromas did you see?
A. One.
Q. And is the reason that you arrive at the opinion that the neuroma was traumatic in nature due to the transection because there was no mesh next to it or adjacent to it?
A. No. That's the pathophysiologic mechanism by which traumatic neuromas develop.
Q. Do you have an opinion as to whether or not the mesh itself migrates within the female body?
A. I do not, no. I have no opinion.
Q. You say in your opinion that Mrs. Gross did not -- I'm sorry, strike that.
You say that in your opinion Ms. Gross had an unremarkable response to the Ethicon mesh, is that correct?
A. Correct.
Q. Have you studied whether and to what extent the inflammatory response

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changes depending on how much mesh is in the female body?
MR. SNELL: Objection to form.
A. Have I studied that myself, no.
Q. Are you aware of any literature that speaks to that issue?
A. No.
Q. Can you tell us within a reasonable degree of medical probability as to how this amount of mesh that's contained within the Prolift system will affect the female body as opposed to a smaller amount of mesh used in several sutures?
MR. SNELL: Objection to form.
A. It's a quantitative process. Where you have mesh, there are areas in which there is adjacent fibrosis and adjacent inflammatory response, in some areas. In other areas, there's almost none. Where you have a suture or sutures, the response is localized to the

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presence of the suture. It does not spread out through the tissue.
Q. Where there's mesh, such as the Prolift mesh, do you know if that inflammatory response builds on itself?
A. I don't understand that question.
Q. Where there's more mesh, such as the amount of mesh we have in the Prolift system, do you know if that insights a much greater multiple of inflammatory response and/or fibrosis as opposed to a smaller amount of mesh you would see in a couple of sutures?
MR. SNELL: Objection to form. Go ahead.
A. The response is associated with the mesh fibers themselves. It's not going -- obviously, if you have multiple fibers, just as if you had multiple sutures in a tissue you would have quantitatively more inflammation in total, but it's a question of whether the mesh fiber has elicited an inflammatory response and how much of it is elicited.

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In many areas, the mesh is not elicited, a significant or, if any, inflammatory response in other areas, there's more of an inflammatory response. Obviously, if you have more mesh, you potentially can have more inflammation.

Q. Are you aware of any literature, Doctor, that talks about the multiplication effect where there's more mesh?

A. I'm not you aware of it and biologically it makes no sense.

Q. Have you reviewed any of Linda Gross' medical records?

A. I reviewed some portions of them. Obviously, I reviewed the operative reports and the surgical pathology reports.

Q. Do you have any opinion as to whether and to what extent Linda Gross suffers from chronic pain as a result of the mesh?

A. I'm aware she's had complaints of chronic pain. Whether it's due to the mesh or not, I don't know.

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Q. I'm to go through some of the slides. I'm going to show you Doctor, what has been marked as Factor 1, which is sample CR07-8397. These are slides you have seen before; correct?

A. Just the ones I got this morning, or this afternoon.

Q. But the --

A. I saw the slides. I saw these pictures today.

Q. Right. But you have seen these slides before?

A. Oh, absolutely.

Q. Let's turn to -- I want to start with -- I guess we'll start with the 13th slide.

A. What is the picture?

MR. MAZIE: Okay. Why don't we change tape.

VIDEOGRAPHER: The time is now 3:30. This is the end of Disc Number 1. We are now going off the record.

- - -

(Whereupon, the following

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was held off the video record:)

MR. MAZIE: We are here with the understanding of taking the deposition of Dr. Factor with regard to both the Gross and the Wicker case. I arrived here today without prior warning. And Mr. Snell told me that he was going to refuse to allow the Doctor to answer questions concerning the Wicker case. Is that correct?

MR. SNELL: You're patently wrong. You were told by Kelly Crawford that we were not producing Dr. Factor, we object to producing him -- producing Dr. Factor in the Wicker case that in light of the fact that, A., Dr. Faulk (ph) is a new expert and he has not been deposed. There's a motion pending on him. B, Dr. Welsh has not even been deposed yet on Wicker. Therefore, we did not believe it would be pertinent or right to produce Dr. Factor in

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the Wicker case concerning that plaintiff's experts have not even been disclosed, let alone one of may not be allowed to so testify in the Wicker case.

So your representation is wrong. Whether you were copied on the e-mail to your partner, Adam Slater, I frankly did not go back and check that.

MR. MAZIE: I was aware you were taking that position, but the judge had said that you should take whatever you can with regard to Dr. Welsh. You were given the opportunity. He was not finished for whatever reason. He was prepared to stay. Kelly decided not to stay. And in either event, the Judge said that we should go ahead and take Dr. Factor on both cases regardless.

MR. SNELL: It's my understanding that was not what happened, that the court reporter

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needed to leave. The Judge said we should focus on Gross first, that's why Kelly focused on Gross first and the Judge has not said that Dr. Factor should be deposed on Wicker in addition to Gross as we sit here today at this deposition. So I think that's attorney/lawyer argument, and if there's a disagreement, it's amongst the counsel.

MR. MAZIE: So we're clear, to the extent you do not allow me to ask questions concerning Wicker and we're not getting in touch with the Judge, we'll seek to move to bar Dr. Factor's testimony in the Wicker case. And to the extent the Judge does not grant that, we're going to ask that the deposition take place at our office at our convenience. Okay.

MR. SNELL: We are fine with producing Dr. Factor for the Wicker case. And Dr. Factor,

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you're fine with giving a deposition in the Wicker case.

THE WITNESS: I have no problem giving a deposition, but it limits the number of days that you have available because I often have to be here at the hospital for portions of those days.

MR. SNELL: So we will produce Dr. Factor here, and it will be done -- I would like to put something else on the record. We offered to move the deposition in toto until after Dr. Welsh was deposed. And I believe Dr. Factor gave a date of December 19th in response to Mr. Mazie's dates that he provided for potential availability in December.

So, that was an offer that we made that was rejected and we've never stated our position was otherwise. So, Dr. Factor -- I'm more than willing to produce him. He's more than willing to be

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deposed on Wicker. But at this point, he should be after Dr. Welsh and after the motion is decided on plaintiff's newly disclosed, last minute expert on the amyloidosis pertinent to the Wicker case, who has refused Dr. Factor's report and opines about it.

MR. MAZIE: I want to place on the record that the first time amyloidosis was ever raised was by Dr. Factor and we turned around and produced an expert within a week or less and that was, by the way, close to a month ago.

MR. SNELL: The fact that Dr. Welsh did not recognize it, I cannot speak to that.

MR. MAZIE: Okay. It's there.

- - -

(Whereupon, a discussion was held off the record.)

- - -

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VIDEOGRAPHER: The time is now 3:42. We are back on the record.

BY MR. MAZIE:

Q. Doctor, I'm showing you what has been, I think, considered to be slide number 14, which is part of Factor 1. Why don't you hold that up for the camera, so we're all on the same page?

MR. SNELL: I think you've identified it as the 13th slide.

MR. MAZIE: It's 13th, but if you include the first page, it's the 14th.

BY MR. MAZIE:

Q. Doctor, can you tell us what is going on in that slide?

MR. SNELL: Objection to form.

MR. MAZIE: What is the objection?

MR. SNELL: What is going on?

MR. MAZIE: Yes.

BY MR. MAZIE:

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Q. What do you see?
A. There are number of fiber mesh spaces with some residual mesh material. A lot of it has been disrupted by technical artifact -- the sectioning of the tissue. There is a longitudinal vessel running obliquely across the humoids (ph). There's several small vessels off to one side, and there are inflammatory cells, including what appears to be lymphocytes and macrophages along with a few multi-nucleated giant cells.
Q. Doctor, fair to say there's active chronic inflammation on this slide?
MR. SNELL: Objection to form.
THE WITNESS: There's inflammation. Again, there's no way to determine that this is active.
BY MR. MAZIE:
Q. And there's, at least, one or two giant cells?

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A. There are several giant cells, both off -- slightly away from the fibers as well as appearing to be near the fibers.
Q. There's chronic inflammation adjacent to the mesh fibers where the chronic fibers were?
A. Chronic inflammation is between the mesh fibers. It's, actually, closest to the blood vessel that runs obliquely through the field.
Q. Just so we're clear, there is chronic inflammation between the mesh fibers; correct?
A. That's just what I said.
Q. And there are, also, giant cells there?
A. There's, at least, one giant cell in that particular area.
Q. Let's turn to the 15th slide. Fair to say that all of the pink stuff you see on this slide is fibrosis?
A. Yes.
Q. And within or surrounding the mesh fibers that you see or where the

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mesh fibers were is fibrosis?
A. It is around the fibers and between the fibers, yes.
Q. You can't give us an opinion as to what the cause of that fibrosis is in this tissue sample from Linda Gross, correct?
MR. SNELL: Objection to form.
A. It's part of the process of the implantation of the mesh and the surgical ailment.
Q. Can you tell whether or not the surgical fibers themselves caused the fibrosis that you see in this slide, number 15?
MR. SNELL: Objection.
A. There's no way to specifically ascribe the fibrosis to the mesh. In fact, in the central portion of the field, there are virtually no fibers and there's still fibrosis and fibrosis extends beyond the mesh fibers. So trying to directly relate the fibrosis to the mesh is not possible.

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Q. You can't tell us one way or the other, correct?
A. Correct.
Q. Next, Number 16, do you see chronic inflammation around the mesh in the slide?
A. Well, this is the same field as the higher power that we saw in the previous, the number 13 or 14, whatever that number was.
Q. Can you see extensive fibrosis in this slide?
A. There is fibrosis that extends around the mesh fibers and extends away from the mesh fibers. The area off to the upper right has no mesh fibers and has the same fibrosis elsewhere.
Q. Let's go to the 26th slide, which looks like this.
A. That's the same field as we have already discussed.
Q. Okay. That's it.
MR. SNELL: Why don't we call it, is it CR078 --

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THE WITNESS: They're all the same, unfortunately.
BY MR. MAZIE:
Q. This shows chronic inflammation, this slide?
A. This is the same field that we saw.
Q. Let's go two more, number 28. We haven't talked about this one yet, have we?
A. Not to my knowledge, no.
Q. This shows fibrosis surrounding the mesh fibers?
A. Yes, with virtually no inflammation.
Q. There's fibrosis surrounding the mesh fibers, correct?
A. I just said so, yes.
Q. And the fibers themselves here, the fibrosis is, actually, pulling the fibers together; correct?
A. Well you --
MR. SNELL: Object to form.
THE WITNESS: -- you can't make that conclusion. There's

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fibrosis and there are fibers, but there's no way you can make a conclusion, especially because there's, also, artifacts in this tissue that the whole -- that is at 12 o'clock, there's a tear in the tissue which disrupts the fibrous tissue.
BY MR. MAZIE:
Q. Doctor, do you know one way or the other whether the fibrosis is affecting the distance between the mesh fibers?
A. I don't know.
Q. Okay. Let's go to Number 33, which looks like that. You might want to count it from the last one, which is 26?
A. Is it this one?
Q. There's a number of them in a row that look alike. So, let's see. The first one you see of this, looks like that.
A. Yes.
Q. So not that one, not the

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next one, the fourth one we're looking at. It's this one.
A. No. It's not that one. It's this one.
Q. Okay. And it's Number 33.
MR. SNELL: Let me get that. What is in front of it?
THE WITNESS: It's the same.
MR. MAZIE: Fourth one of this series.
MR. SNELL: You are saying this is page what?
MR. MAZIE: 33.
BY MR. MAZIE:
Q. Doctor, what do you see there?
A. I see a portion of fiber. I see a few inflammatory cells. I see some spaces off to the upper left.
MR. MAZIE: I need to pick this up. I'm sorry.
VIDEOGRAPHER: The time is now 3:50. We're going off the record.

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- - -
(Whereupon, a brief recess was taken.)
- - -
VIDEOGRAPHER: The time is now 3:51. We are back on the record.
BY MR. MAZIE:
Q. Doctor, you see the degradation of that mesh fiber there?
A. I see changes associated with the edge of the mesh. I can't tell whether that's pre-existent degradation or changes associated with the sectioning because there artifacts associated with the sectioning. The mesh fiber, actually, can be seen in its entirety on the two photographs next, which shows polarization of that mesh fiber and shows it intact.
Q. Let's go to Number 35. Do you see the polarized portion -- it's all polarized, but you see the colored portion in the middle of the mesh fiber?
A. Yes.

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Q. Fair to say there's degradation of that mesh fiber?
A. I don't know that's, in fact, the case. There's tearing of the tissue. There's a -- what looks like connective tissue or inflammatory tissue that's crossing that space. And I cannot tell whether that is degradation of the surface or a portion of the surface or is a disruption secondary to sections artifact.
Q. Just so we're clear --
VIDEOGRAPHER: The time is now 3:52o. We're going off the record.
- - -
(Whereupon, a brief recess was held.)
- - -
(Whereupon, the following discussion was held off the video record:)
-- -
THE COURT: Hello, Counsel.
MR. SLATER: Hello, Judge.

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THE COURT: Hi, how are you, Adam?
MR. SLATER: Fine, thanks. How are you?
The COURT: Good. So we have Adam Slater on the record and Ms. Crawford.
MS. CRAWFORD: Kelly Crawford.
THE COURT: Okay, good. So we have a certified court reporter taking down the record?
MR. MAZIE: Judge, it's Dave Mazie and Burt Snell. Unfortunately, we only have an iPhone on speaker. It is next to the court reporter, but she's going to have some difficulty. So everyone needs to keep their voices up. We're at the deposition of Dr. Factor.
THE COURT: So what is the issue?
MR. SLATER: The issue, your Honor, is that my partner, Dave

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Mazie, was -- before starting the deposition, he was informed by the defense he was not to ask any questions of Dr. Factor about the Wicker case. And we are prepared to proceed and take the deposition fully on both cases, and we think we should be permitted to fully take the deposition today.
THE COURT: Is the deposition as to Gross completed?
MR. MAZIE: Judge --
MS. CRAWFORD: Kelly Crawford. I don't know if you're directing that at me.
THE COURT: Go ahead, Kelly.
MS. CRAWFORD: I'm not at the deposition, Judge, but as I understand it, Mr. Snell can confirm, they're in the middle of the Gross deposition regarding Dr. Factor at this point and it's not yet completed.
MR. MAZIE: Judge, Dave Mazie. I will be done with the

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Gross deposition within the next 20 to 30 minutes and ready to proceed and finish up with the Wicker deposition, which quite honestly, will not take more than an hour.
MS. CRAWFORD: If you're prepared for defense's position, Judge, just let us know.
THE COURT: Go ahead, Kelly.
MS. CRAWFORD: We took Dr. Welsh's deposition. Your Honor will recall at the last case management conference this issue came up in connection with the defendant's pending motion to stay the Wicker specific case discovery. And we talked specifically at the case management conference about the fact that the pathologist -- defendant's -- plaintiff's expert pathologist is going to be deposed on the 16th before the Court was going to have an opportunity to

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address that motion. And the Court indicated that we should start with Gross and, you know, try the finish Gross and if there was time available to move on to Wicker. We did not start Wicker. We completed Gross. But it had been our position that we are not prepared now prepared to produce Dr. Factor and have him deposed on the Wicker until we complete the Welsh corresponding deposition in Wicker, and that hasn't happened.

THE COURT: Welsh would have to go before Wicker?

MS. CRAWFORD: Correct.

THE COURT: Is he before?

MS. CRAWFORD: That is our position, Judge. We will recall we had made the motion to stay Wicker's specific case discovery. We talked -- or I didn't talk at that conference, Mary Ellen was my mouthpiece because I couldn't talk -- about the fact that we had

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that deposition scheduled for Friday and your Honor was going to try to set up a call for --

THE COURT: Right.

MS. CRAWFORD: -- the week, but everything got sort of busy.

MR. SLATER: Your Honor, it's Adam Slater. It doesn't really make sense to us. Defense counsel they took the deposition they wanted to take. It was a very long deposition and they didn't finish, or they finished Gross and didn't have time to do the Wicker questioning. I don't know how that impacts us on the deposition of Dr. Factor. We just want to get it done while we're here. It's counsel's choice not to finish. You know, it turns out it seems like it was a strategy or something. We don't really understand why, or maybe we do understand why they don't want us to take Wicker discovery, so the

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case will be ready. But we're in New York and ready to take the deposition of Dr. Factor, and it will be done.

MS. CRAWFORD: Judge, I don't want to get into an issue about that. I started the deposition on time. We took no break, except for ten minutes so the court reporter can quickly shovel in something to eat. We were there until 7 o'clock. I rushed to try and finish the Gross aspect of the deposition. We do have a pending motion on this issue. We are all spinning our wheels trying to complete the Gross specific discovery in order to be ready for trial. And Dr. Factor is willing to come back at a later time after we had the opportunity to take the Wicker deposition from Dr. Welsh, assuming that your Honor denies the motion that's pending, which

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is still open.

THE COURT: Okay.

I have had an opportunity to review the motion. I read the papers on both sides. It was, I think, important that both cases be prepared and that they be jointly prepared, but there comes a practical point where it simply becomes too much of a burden on both sides to get ready for a case that's not going to be the one that's going at this point.

I understand Mr. Slater's concern that Wicker would be the back up case. And Ms. Crawford, at the last conference, had indicated to me that there was slim and no chance of a settlement offer being made to resolve the Gross case prior to trial. And that, unless the defendants -- the plaintiffs intended to dismiss it, it would be going, barring some unusual event such as a death or

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an injury or something.
Wicker just got treatment. She needs to have the examination and I think it's scheduled, right?
MR. SLATER: That happened yesterday, Judge.
THE COURT: So his report should still issue in a timely fashion. That doesn't take up counsel's time, except maybe to discuss it with him, but it doesn't take up significant time. So, his -- the defense report should issue, the Wicker defense report, but I'm not going to require that the rest of the Wicker discovery take place between now and the trial.
If anything happens to the Gross trial, we'll immediately do the Wicker discovery within a week or two and move on to the Wicker trial, but I'm assuming that's not going to be necessary. There does come a point where it's now the

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end of the week, it's going to be December. Trial is in January. We have, you know, a holiday week in there, at least, simply a couple different holidays, and I'm not going to require -- so I'm going to grant the defense motion to stop the Wicker discovery pending the outcome of the Gross case.
The only thing that I am going to require is that the defense independent medical exam, which has been done, that that report issue in a timely fashion as scheduled previously. And then, basically, you will have some clean-up depositions to do. But we can move very quickly to Wicker if we needed to. All right?
MR. MAZIE: Thank you, your Honor.
MR. SNELL: Thanks, Judge.
MR. SLATER: Thank you,

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Judge.
VIDEOGRAPHER: The time is now 4:03. We are back on the record.
BY MR. MAZIE:
Q. Doctor, just so I'm clear, you have no opinion one way or the other as to whether this represents degradation of the mesh?
MR. SNELL: Objection to form.
BY MR. MAZIE:
Q. As a natural process of the mesh.
MR. SNELL: Objection to form.
A. It cannot be determined whether the changes that are present just at the edge or the end of that fiber represent any degree of degradation or changes associated with the technical processing of the tissue. The remaining portion of that fiber as seen in the polarized photograph appears to be smooth and unremarkable.

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Q. But you don't have an opinion as to what the cause of what is occurring at the end of that, whether it's degradation, naturally occurring or something else?
MR. SNELL: Objection to form.
A. Correct.
Q. Let's go to slide number 51, which to make it easier for you is the 5th from the end. Yes.
Fair to say that you see mesh fibers here encased in or surrounded by fibrosis?
A. I see mesh fibers with fibrosis and I see fibrosis without mesh, with spaces that I -- that are more likely than not fat or disruption of the tissue in the center and off on the far right, but certainly the ones in the center are not mesh, but there is fibrous around it.
Q. You see multiple mesh fibers or holes where fiber was, correct?
A. And there are multiple mesh

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fibers. There are a few tears in the tissue above the mesh on both sides and there is fibrosis around those fibers.
Q. As you sit here today, you cannot tell us specifically what caused the fibrosis surrounding these mesh fibers?
MR. SNELL: Objection to form.
A. I've answered the question before that the fibrosis is part of the surgical repair process.
Q. But you can't tell us whether it's the actual surgery as an insult to the tissue versus a cause instead by the mesh fibers themselves reacting with the tissue?
MR. SNELL: Object to form.
A. The fact that the fibrosis is present in this field as well as in many other fields without any mesh fibers immediately associated with it would argue that this is a process of surgical repair.
Q. What about in the areas that

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immediately adjacent to the mesh fibers?
A. It's the same fibrosis. So one can't -- as I pointed out earlier, one can't easily discriminate between fibrosis associated with repair versus fibrosis associated with mesh.
Q. Can or can't?
A. Cannot.
Q. Let's go to the second to last slide, which is number 53. I'm sorry, third to the last slide. The one with the hemosiderin in the middle.
A. Yes.
Q. What do you see here, Doctor?
A. I see fibrosis, some, I believe, small blood vessels cut longitudinally and I see multiple hemosiderin deposits and macrophage.
Q. Does this slide demonstrate chronic injury?
A. It demonstrates injury with chronicity because the collagen is mature and the macrophages are in response to the hemosiderin, so this is a chronic

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process.
Q. Do you see any inflammation on that slide?
A. I described the inflammation. There's macrophages and there may be a few lymphocytes scattered around, but the predominant cells are macrophages.
Q. Put this grouping aside. And let's go to Welsh 14, and ask you to go -- these are numbered, so that will make it easier.
MR. SNELL: Do you by chance have a copy?
MR. MAZIE: No.
MR. SNELL: I'm just going to look over.
BY MR. MAZIE:
Q. Doctor, go to 62. What do you see there?
MR. SNELL: Objection to form.
A. I see a central area which appears to be -- it's not forming a true granuloma, but it appears to be a

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granulomatis-type process with even at the low power, I think spindle cells, fiberglass and what happens to be hemosiderin and inflammatory cells. There's a space running vertically or relatively vertically which appears to be a blood vessel, but I'm not entirely sure. Portions of it appear to be blood vessel.
Q. Do you see in -- is there, also, fibrosis?
A. There's fibrous tissue around the central area of inflammation and hemosiderin.
Q. Let's jump to number 70. It's fair to say this slide shows chronic inflammation?
MR. SNELL: Objection to form.
A. It's a terrible picture and it's difficult to make out, but there are what appears to be giant cells, some of them are multinucleated and lymphocytes with, at least, some of the giant cells appearing, even though it's difficult to

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make out on this exposure. It appears that they have hemosiderin within them or near them.
Q. Do you see any mesh?
A. No.
Q. The amount of inflammation you see here, is that something you would expect from a normal surgical process without a foreign body?
MR. SNELL: Objection to form.
A. If this is an area that has had extensive bleeding and disruption, this is a normal response. There, obviously, has been bleeding because there's hemosiderin throughout the tissue. It's hard to make out the full extent of this process from this view and from the exposure.
Q. Let's go to the next one, number 71. Can you interpret for me the cluster of dark cells in the pink area?
A. There are --
MR. SNELL: I object to the form. Are you -- any particular

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place you're referencing?
MR. MAZIE: There are dark cells. I think he understands what I'm asking. There's an accumulation of the dark cells in the middle to left of the center.
THE WITNESS: There are lymphocytes or they appear to be lymphocytes. There may be monocytes in there. It's hard to see whether or not there are macrophages, I think there are a few. There are -- there's, at least, one vessel, possibly represents the same vessel, cut in several planes, but there are vessels adjacent to this cluster of inflammatory cells.
BY MR. MAZIE:
Q. Let's go to 73, Doctor.
A. 73.
Q. Yes. Doctor, do you see chronic inflammation on the this slides?
A. It's the same picture that we had before. It's the same field.

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Q. It shows --
A. Lower magnification.
Q. Number 73 shows chronic inflammation?
A. Yes.
Q. It shows scarring?
A. It shows fibrous tissue, yes.
Q. Does it show nerve?
A. It shows a longitudinal segment of myelinated nerve.
Q. Is there mesh fiber shown?
A. There are spaces, but I don't believe those are mesh spaces.
Q. Why not?
A. Because I believe they're too small. I believe that's fat.
Q. When you say they're too small, again, you don't whether or not the mesh fibers themselves squeeze or contract?
MR. SNELL: Objection.
A. They don't change their diameter overall and all the spaces that we have seen which have mesh are much

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large than those three spaces that we see adjacent to the nerve.
Q. Why don't you think they change their overall diameter?
A. Because I see no evidence of it. The spaces are relatively the same size or the fibers that one can see with light microscopy, H&E, light microscopy and with polarization show fibers that are of a similar size.
Q. You're basing your opinion on the 18 or so slides that you've looked at?
MR. SNELL: Object to the form.
A. Yes.
Q. Okay. You don't know whether and to what extent the mesh fibers contract because you haven't seen most of the mesh fibers within Linda Gross' body or pulled out of her body, correct?
MR. SNELL: Objection to form.
A. It's irrelevant what's been

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pulled out of her body. It's is irrelevant what I haven't seen. What I have seen is clear that the mesh fibers show no evidence of retraction or contraction. The spaces are enlarged. Some are larger than one would anticipate, but that is a technical artifact of dragging with spaces and disrupting the fibers. These spaces that are off to the right, at least from this view, and, obviously, this is showing the whole field, I do not believe are mesh, nor is there any mesh evidence with any mesh fiber that I can see at this magnification within those spaces.

Q. Doctor, you understand that there is clear testimony from both sides that the mesh contracts within the female body? Do you know that?

A. Well, there's contraction of scar tissue or fibrous tissue which is recognized with any scar. All scars will retract to some degree. Fibrous tissue, and obviously when one cuts the skin, gets a scar. One knows that scars

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retract or fibrous tissue retract. So that's not unusual. It's not unique. It has nothing to do specifically with the mesh. Its the natural property of the fibrous tissue.

Q. Listen my question.

A. I did.

Q. You understand that it's undisputed that the mesh contracts.

MR. SNELL: I object to the form. That's actually a misrepresentation.

A. I don't know that that's the case. It is -- since the mesh is enveloped or surrounded by fibrous tissue that extends through the mesh pores, the process of retraction or contraction is potentially only due to the fibrous tissue healing.

Q. Either way, whether it's the fibrous tissue causing the contraction or the mesh itself causing the contraction, you understand that the mesh once implanted contracts, correct?

MR. SNELL: Objection to

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form.

A. Again, I don't know that -- that indicates or that implies that the mesh has an active process of contraction independent of what is going on in its implantation site and that's not the case. The mesh is implanted in the tissue. It elicits an inflammatory and fibrous reaction and that fibrous reaction retraction contracts. I have no evidence that the mesh itself is an active participant in that process.

Q. I understand that. I think we're saying the same thing. So once the mesh is implanted, it interacts with the female tissue; correct?

A. Well, it interacts with the fibrous tissue that's part of the healing process.

Q. And then that fibrous tissue causes the mesh itself to contract in size; correct?

MR. SNELL: Objection.

A. Potentially, yes.

Q. Page 75, last one on this.

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Doctor, you see a nerve there?

A. There's a nerve cut across by the -- whatever that disruption is in the picture. But, yes, there's a nerve.

Q. And there's chronic inflammation near the nerve?

A. There's chronic inflammation near the nerve, but it's associated with fat.

Q. Do you see any fibers, mesh fibers?

A. I do not know what is off to the far left. I don't believe it is, but it possibly could be, but all the remaining spaces are fat tissue, both above the nerve and below the nerve.

Q. In order to have pain, is it your position you have to have neuritis?

A. You either have to have neuritis or evidence of disruption, damage to the nerve fiber. Whether the surrounding of nerves by fibrous tissue is sufficient to produce pain is unknowable. There is potential for secretion of irritant materials that

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could lead to pain, but there's absolutely no way biologically to determine any one nerve or any group of nerves is the source of a particular pain when you are dealing with nerves of the size. The absence of inflammation, the absence of neuroma formation with the exception of that one that I mentioned earlier, is a normal response of nerves in tissue that is undergoing fibrosis and some degree of inflammation.

Q. Just so we're clear, you can't tell one way or the other whether fibrosis is causing a nerve to cause pain?

A. Nobody can.

Q. Okay. All right. Put that one away. Let's see what else we have here.

Number 12. Welsh 12, I will ask you to look at a couple of slides here. Number 36, which is the second slide, what do you see there?

A. I see.

MR. SNELL: Objection to

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form.

A. I see a nerve that's been, I assume, inked or surrounded by ink that looks to be irregular and surrounded by fibrous tissue.

Q. And go to number 47, please.

A. 47, you said?

Q. 47. Do you see a nerve there?

A. There are nerves or there is, at least, one nerve off to the right. I don't know what the tissue is in the center of the field.

Q. Okay. Can you tell whether the nerve itself is degenerated?

A. The nerve that I see off to the right is not. I don't know what the remaining tissue is.

Q. Is the nerve itself imbedded in the fibrosis, the one you see?

A. Well, there's a space around the nerve, but that's probably retraction. So, yes, the nerve is surrounded by fibrous tissue.

Q. Put that one away. Let's

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look at number 8, and look at number 3 on this. Do you see a nerve there?

A. I do.

Q. Is it normal or degenerated?

A. It looks partially torn. The portion of it that appears to be unaffected off to the center towards the left appears normal. It looks like there is some disruption of the nerve possibly by a sectioning.

Q. You can't tell us within a reasonable degree of medical probability as to what disrupted this nerve?

MR. SNELL: Objection to form.

A. Well, since only a portion of it is affected and there's no inflammation associated with it and no difference in the fibrosis that's around it, I believe it's due to the sectioning.

Q. Doctor, what is around the fibrous?

A. Fibrous tissue and a few inflammatory cells.

Q. Is there some collagen as

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well?

A. That's fibrous tissue. Collagen is fibrous tissue.

Q. Let's go to number 4. Does this show a damaged or dying nerve surrounded by collagen?

MR. SNELL: Objection to form.

A. It shows a nerve. It's not damaged or dying.

Q. What do you see?

A. I see a nerve in three different planes, or two different planes.

Q. Can you tell whether or not the nerve itself is degenerated?

A. It does not look degenerated.

Q. Turn to number 5. Do you see a nerve there?

A. It's the same nerve, I believe.

Q. And can you tell whether that nerve is degenerated?

A. It wasn't degenerated on the

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high magnification, so it's not degenerated on this, either. It, also, shows that there's multiple technical artifacts in the tissue immediately around the nerve.
Q. Number 13, do you see the nerve?
A. There are three nerves.
Q. Is there fibrous tissue surrounding the nerves?
A. Above the nerve, there is fibrous tissue and tearing. And below the nerve, there is fat necrosis.
Q. Which nerve are you referring to, the one on the right?
A. I'm referring to all three of the nerves that run, more or less, through the center of the field.
Q. Turn to number 14. Can you identify for us the circled vessels?
A. Can I identify them?
Q. Yes.
A. One of them is a vessel. The other -- or two of them are vessels. The other are damaged by sectioning.

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They're tangential and the tissue is not easily seen and, actually, even the other two have the same problem. There's a tangential sectioning, the two vessels that I believe I can recognize in the right center and upper portion.
Q. So the first on the upper right and the one right below it?
A. Not the upper right. That one is not -- cannot be evaluated because of its tangential sectioning and destruction of the tissue.
Q. Can you point?
A. This one.
Q. That one cannot be?
A. No.
Q. So which one --
A. So this one is a vessel and this one is a vessel, both of them because of the smudginess of the inner lining, they're not cut appropriately across, so they're difficult to evaluate. The other two above and below, and I'm not sure what this is, and this, cannot be evaluated at all.

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MR. SNELL: So the record --
MR. MAZIE: I'm going to do it right now.
BY MR. MAZIE:
Q. The ones you say are vessels, there are three circles to the right and it's the middle one?
A. The middle one is a vessel, but even that is not appropriately cut across in such a way that it can be evaluated. The one to the --
Q. Left?
A. -- to the upper left is longitudinal or oblique and it, too, shows smudginess of the lining, the endothelium and cannot be adequately assessed.
Q. And that drawing, just so we're clear, is the upper left shaped like a pickle?
A. Or other structures, yes.
Q. The surrounding tissue, especially in particular in the bottom left quadrant, do we see collagen and fibroblast?

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A. I believe there is collagen and there appears to be fibroblast.
Q. Let's go to number 15. Do you see a damaged vessel there?
A. It's very difficult to make -- I mean, I believe there's a vessel in the center that's been circled. Again, it's longitudinal. It's not a nice cross-section. So it's difficult to make sense out of it. The lower portion of it is out of focus. So it's hard to know what to make of this.
Q. Okay. Let me show you the last set which is 10. Let's go to number 4. Is there any info -- strike that.
Is there any information here as to the pore size in vivo?
MR. SNELL: Objection to form.
A. No. One can't measure the pore size in fields like this. I mean, one can approximate it because the individual fibers have a certain diameter, but it can't be a precise measurement.

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Q. Can you approximate the size of those pores?
A. Not without a micrometer or ruler, no.
Q. We're here at your deposition. You are not, as to this point, rendering any opinion on the size of any of the pores?
MR. SNELL: Objection.
A. Correct.
Q. Next one, number 5, is it fair to say that on this polarized slide, the white is the mesh that's remaining within this sample?
A. The few fibers, yes, or fragments of mesh that are in the sample.
Q. Number 6, is that all mesh?
MR. SNELL: Objection to form.
MR. MAZIE: Strike that.
BY MR. MAZIE:
Q. Do you see mesh on this?
A. Well, I don't specifically -- I see some spaces that I believe are mesh, some of the spaces

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appear to be tearing of the tissue. I'm not quite sure what several of the other spaces are. They may be vessels in here. It's difficult to tell.
Q. Let's go to the next slide, which is polarization. The white stuff, is that all mesh?
A. Yes.
Q. Let's go to number 10. This slides shows hemosiderin?
A. This slide shows hemosiderin and some lymphocytes and a few macrophage.
Q. What is shown in the lower quadrant there, lower right quadrant?
A. Fibrous tissue.
Q. Is there mesh within it?
A. There's one space that appears to be a complete mesh fibrous space and another that is an incomplete space.
Q. Let's go to number 12. Does this slide show chronic inflammation?
A. It shows a few areas of chronic inflammation in the center, a

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little bit off to the left and a little bit off to the right.
Q. Is the chronic inflammation adjacent to mesh fibers?
A. It's in the general vicinity of mesh fibers, yes, but not directly associated with it.
Q. Can you tell one way or the other whether the mesh fibers incited any of the chronic inflammation shown on this slide?
A. It's part of the process of fibrosis and mesh placement. I'm sure the mesh has some relationship to it, but it's not an obvious one.
Q. Do you see any lymphocytes?
A. I believe this micro -- this power, which is a low power, the small cells are more likely than not lymphocytes.
Q. Okay. You can put that away. Let me see if I have anything else for you.
Doctor, do you have an opinion as to whether or not the mesh

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itself migrates or moves?
A. I don't have an opinion.
MR. MAZIE: That's all I have. Thank you.
THE WITNESS: Okay. Thank you.
MR. SNELL: I have a couple quick ones.
- - -
EXAMINATION
- - -
BY MR. SNELL:
Q. Did you see any evidence of of degradation?
A. No.
Q. Plaintiff's counsel asked you some questions about the inflammatory state and chronic inflammation. Do you, in general, recall those questions?
A. In general, yes.
Q. What do you consider to be chronic inflammation?
A. Again, it comes back to what I indicated before. Chronic inflammation refers to a subset of inflammatory cells

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that are predominantly lymphocytes, monocytes, macrophages and giant cells, but there's, also, a temporal component and that is, as tissue injury heals, there are inflammatory cells that are associated with the healing process and they, then, persist in the tissue to varying degrees.

Q. And I believe you identified that Mrs. Gross had chronic inflammation associated with factors other than mesh, is that correct or not?

A. There were chronic inflammatory cells in a number of different areas of her tissues associated with hemosiderin deposition and -- and/or fat necrosis.

Q. Has any of the pictures that plaintiffs have showed you today changed any of the opinions that you submitted in your written report in the Gross case?

A. No.

Q. Do you hold all those opinions, including the opinions today, to a reasonable degree of medical

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certainty?

A. I do.

Q. If I asked questions about the degree of inflammation and Mrs. Gross' inflammatory state, beyond the -- beyond what was specifically seen on certain slides, will you, indeed, render such opinions on the nature of her inflammatory state?

MR. MAZIE: Objection as to form.

A. Yes.

Q. In your report at page 5, you state that the inflammatory changes -- on the third paragraph below, "the inflammatory changes were not significant and they were highly variable."

A. Yes.

Q. That's an opinion you hold today?

A. Yes.

Q. You, also, write, "Her tissues had evidence of fat necrosis and hemorrhage that independently led to

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further scarring often in areas distant from mesh fibers. The entrapment of some nerves and the sclerosis of blood vessels was a result of surgical manipulation of the tissues and cannot be linked to speculative and biologically unsupported effects of the mesh."

That's what you wrote?

A. Yes, I did.

Q. Is that your opinion today as well?

A. It is.

MR. SNELL: That's all I have. Thank you.

MR. MAZIE: Okay.

VIDEOGRAPHER: The time is now 4:38. This is the end of disk two. This completes today's deposition.

- - -

(Whereupon, the videotaped deposition concluded at 4:38 p.m.)

- - -

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C E R T I F I C A T E

I HEREBY CERTIFY that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

_____

Margaret Peoples, RPR
Dated: November 27,2012

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

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You are signing it subject to the changes you have made in the errata sheet, which will be attached to the deposition. You must sign in the space provided.

Return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the transcript by you.

E R R A T A

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, 1 through 135 and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

STEPHEN M. FACTOR, M.D. DATE

Subscribed and sworn to before me this _____day of_____, 20_____.

My commission expires:_____

_____

Notary Public

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